

**University of St. Thomas, Minnesota**  
**St. Catherine University**

---

Social Work Master's Clinical Research Papers

School of Social Work

---

2016

# Exploring Shame Within the Supervisory Relationship

Kendra Holloway

University of St. Thomas, Minnesota, [kendraholloway99@gmail.com](mailto:kendraholloway99@gmail.com)

Follow this and additional works at: [https://ir.stthomas.edu/ssw\\_mstrp](https://ir.stthomas.edu/ssw_mstrp)

Part of the [Clinical and Medical Social Work Commons](#), and the [Social Work Commons](#)

---

## Recommended Citation

Holloway, Kendra, "Exploring Shame Within the Supervisory Relationship" (2016). *Social Work Master's Clinical Research Papers*. 586.  
[https://ir.stthomas.edu/ssw\\_mstrp/586](https://ir.stthomas.edu/ssw_mstrp/586)

This Clinical research paper is brought to you for free and open access by the School of Social Work at UST Research Online. It has been accepted for inclusion in Social Work Master's Clinical Research Papers by an authorized administrator of UST Research Online. For more information, please contact [libroadmin@stthomas.edu](mailto:libroadmin@stthomas.edu).

## Exploring Shame within the Supervisory Relationship

by

Kendra L. Holloway, B.A.

MSW Clinical Research Paper

Presented by the Faculty of the  
School of Social Work  
St. Catherine University and the University of St. Thomas  
St. Paul, Minnesota  
In Partial Fulfillment of the Requirements for the Degree of  
Master of Social Work

Committee Members  
Lisa Kiesel, MSW, Ph. D., LICSW (Chair)  
Jane Hurley-Johncox, MSW, LICSW  
Ellie Jones, MSW, LGSW

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

# SOCIAL WORK SUPERVISORS' RESPONSES TO SHAME

## **Abstract**

The importance for supervisors to approach shame in their supervisees is outlined in the research, as well as methods that supervisors can utilize to promote shame resiliency in supervisees. The purpose of this study was to gain knowledge about shame within the supervisory relationship from a social work perspective, as this topic has been primarily examined through the field of psychology. This qualitative study of five LICSW supervisors served to educate the social work community, both supervisors and supervisees, about the concept of shame in supervision and the perceived best ways of approaching it. The findings formed into seven themes for approaching shame in supervisees: building a safe relationship conducive to talking about shame, directly addressing the shame, processing the shame, individualized approaches to supervisee shame, workplace considerations, supervisor support, and methods of evaluating approaches to shame. A discussion on the similarities and differences between the current research in this area and the findings of this study are outlined, as well as implications for social work practice and research.

*Keywords:* clinical supervision, shame, social work

## SOCIAL WORK SUPERVISORS' RESPONSES TO SHAME

### **Acknowledgements**

I must give a huge thank you to my research chair, Dr. Lisa Kiesel. My success was in large part because of your support, guidance, and brilliant research expertise. Thank you for the structure you provided throughout the past nine months; it made this larger than life project doable.

Thank you to my research committee members, Jane Hurley Johncox and Ellie Jones, for your insight and support. I feel so grateful for all of the efforts you put towards helping me complete this project.

For the LICSW supervisors who took time out of their busy schedules to participate in this research study, thank you!! Your honest and authentic responses made this project such a success. Thank you for contributing to social work research.

To my husband, Kyle, and son, Grey, thank you for your unwavering love, support, and understanding through this research project and the last three years of graduate school. You are my strong foundation and inspiration for everything. Thank you!!

Thank you to my parents, Kevin and Margie, who taught me to work hard and continue to pursue my goals even amidst challenges.

Thank you to my fellow social work friends in the MSW program. I am grateful for our mutual support throughout this research project and the friendships we have formed.

**Table of Contents**

Introduction.....	2
Literature Review.....	4
Conceptual Framework.....	21
Methodology.....	23
Findings.....	29
Discussion.....	48
References.....	59
Appendices.....	66

# SOCIAL WORK SUPERVISORS' RESPONSES TO SHAME

## List of Tables

Table 1: Participants' Demographics.....31

Table 2: Participants' Responses to Supervision Style.....35

## List of Figures

Figure 1: Participants' Concept of Shame.....32

Figure 2: Participants' Responses to the Purpose of Supervision.....34

Figure 3: Themes Regarding Social Work Supervisors' Responses  
to Shame in Supervision.....36

Shame is a commonly experienced and multifaceted human emotion that social workers often encounter within their practice and personal life. Brown (2006) describes shame as, “an intensely painful feeling or experience of believing we are flawed and therefore unworthy of acceptance and belonging” (p.45). Clinical supervision is an ideal setting to discuss and address a social worker’s own thoughts and behaviors including shame, however, shame is rarely dealt with during supervision (Alonso & Rutan, 1988; Kaiser, 1992). Research around shame continues to grow, but specific research regarding effective strategies at addressing shame in clinical supervision is lacking. Additionally, research is scant that examines shame within supervision in the field of social work in particular.

The purpose of this qualitative research study is to gain knowledge of how shame manifests within social work supervisees. Also, this research study aims to better understand how social work supervisors perceive to be effective at addressing shame within their supervisees through the supervisory relationship. This research values social work supervisors’ emic perspective in exploring the best ways to cope with shame when it arises within their supervisees.

Shame is a negative, self-conscious emotion, which manifests from a negative reflection of the self and has serious implications interpersonally and psychologically. Shame also serves a purpose as a moral emotion by encouraging moral behavior (Tangney & Dearing, 2002). Additionally, because of the values upheld in today’s scarcity culture, shame permeates frequently from the idea that we are never enough. We continually strive to work harder, do more, become more successful, and try harder. These cultural values naturally evoke a shame reaction because the unrealistic demands are impossible to meet.

Although social workers often assist others in dealing with difficult emotions, they are not insusceptible to experiencing shame themselves. Social workers need to cope with their personal feelings of shame for their own well being and in order to best serve their clients. Feelings of shame, if not dealt with have found to be related to psychopathology (Averill, Diefenbach, Stanley, Breckenridge, & Lusby, 2002).

Clinical supervision is a requirement for social work students and beginning social workers in practice and is recommended as an ongoing support for good practice beyond these requirements. Social work supervisors have the opportunity to intervene in addressing shame within their supervisees during clinical supervision. Research has provided knowledge on how shame manifests within psychotherapy supervision, but this topic has not been explored within the realm of social work supervision specifically. There is more to learn on the approaches of dealing with supervisee shame within supervision, specifically within social work.

This study will attempt to understand how clinical social work supervisors define shame, and will explore how clinical social work supervisors respond to shame in their supervisees. The research question asks, "What approaches do social work supervisors perceive to be effective in responding to shame within their supervisees?" This research also aims to investigate how clinical social work supervisors evaluate the effectiveness of their strategies in coping with supervisee shame.



### **Literature Review**

The topic of shame has become a popular area of research. Many researchers have attempted to define and explore shame within a variety of settings. It is important to understand how research on shame has evolved, in order to better understand this complex human experience within the context of the social work supervision relationship. Research has been conducted linking shame to psychopathology (Averill, Diefenbach, Stanley, Breckenridge, & Lusby, 2002). The concept of shame has also been explored within social work practice (Gibson, 2014) and psychotherapy supervision (Alonso & Rutan, 1988; Yourman, 2003; Chorinsky, 2003; Doherty, 2005; Hemlick, 1997; Samec, 1995; Hahn, 2001). These studies examined shame within the supervision relationship in the fields of counseling, clinical, social, and developmental psychology. They found the following aspects help promote shame resilience in the supervisory relationship: awareness of the relationship, acknowledging power and authority, supervisor techniques and personality, administrative duties, valuing diversity in opinion, feedback, supervisor self disclosure, techniques of promoting supervisee's self esteem, and use of the parallel process. The majority of these research participants were psychology interns, psychology students, licensed psychologists, and psychiatry residents. Some of these studies have included social work participants, however, there is a lack of research exploring shame exclusively within the clinical social work supervisory relationship.

This literature review will begin by defining key terms and concepts related to shame and supervision to provide a foundation for this research. Then, an overview of shame resilience theory is outlined, which includes specific techniques to improve shame resilience, barriers to shame resilience, and how to move past these barriers. Clinical supervision is defined and models of supervision are explored. Challenges within social work supervision are discussed to

understand the barriers, which supervisors and supervisees face within the supervisory relationship. These challenges can impinge on promoting shame resilience within supervision. Next, research on supervisee shame within practice is highlighted, to provide context to the complexities supervisees face as they begin their practice as clinical social workers. Finally, research about shame within psychotherapy supervision is investigated, providing a solid foundation for this research study.

### **Shame**

Shame, one of the most basic yet complex human emotions, shapes both self-identity and relationships with others. “Shame is an extremely painful and ugly feeling that has a negative impact on interpersonal relationships” (Tangney & Dearing, 2002). The experience of shame has been described as feeling self-conscious and being exposed, revealing a personal deficit in some way (Kaufman, 1980). Similarly, Brown (2006) associates shame with “being trapped, powerless, and isolated” (p.45). Consequently, shame can have devastatingly powerful effects on one’s perception of the self and their relationships with others. Kaufman (1980) described that shame initially develops within interpersonal relationships. Shame then becomes internalized and has the power to mold a person’s identity resulting in “feeling seen in a painfully diminished sense” (p. 9).

**Shame’s purpose.** Much of the research highlights that shame serves the purpose of limiting socially undesirable actions, which makes it a moral emotion (Dearing & Tangney, 2001). Individuals experience shame when they feel they have done, thought, or felt something to be morally wrong in their eyes or through another’s viewpoint (Tracy, Robins, & Tangney, 2007). As an individual strives to conform to the moral standards of society, one is bound to make mistakes, which threaten that individual’s emotional stability through the experience of

self-conscious emotions. Shame surfaces when these feelings of inadequacy are internalized and attack one's sense of self.

**Differentiating between shame and guilt.** Previous research has consistently made a point to distinguish the difference between guilt and shame. For example, Brown suggests that guilt is "I did/said/ believed something bad" whereas shame is "I am bad" (Brown, 2006, p.50). Shame and guilt are often seen as two clearly different emotions, however, consistently are not defined distinct of one another (Tangney & Dearing, 2002). Shame and guilt have been independently distinguished from one another from multiple perspectives including psychoanalytically and anthropologically. Guilt has shown to be more adaptive than shame, often resulting in improved relationships with others through apology and confession. Whereas shame often results in an individual avoiding and escaping whatever it was that brought about the shame (Tracy et al., 2007).

The pervasive effects of shame negatively impact one's mental health. Dearing and Tangney (2011) describe shame as "a prevalent and painful emotion that arises frequently in everyday life and that can contribute to the psychological difficulties that cause people to seek treatment." Shame continues to negatively persist because it is rarely spoken and continues to internally fester. Brown (2009) found shame to be a "silent epidemic" which she has concluded from her qualitative research with men and women about shame (p.1). Shame has become a taboo topic of discussion, even among mental health professionals. Mental health professionals are not talking about shame, not even with clients who are known to likely be experiencing shame as with people experiencing depression, addiction, and violence (Brown, 2009).

Van Vliet (2008) found in her grounded theory study of shame and resilience in adulthood that "shame is an assault on the self" and results from "social, moral, or personal

transgressions, personal failures, social rejection, or trauma” (p.235). Shame results from negative self-perceptions of identity and damages connections in relation to social experiences and the environment. Experiences of shame are unique to each person, however, research identifies four common experiences as a result of shame. “Individuals experience shame as an attack on self, attack on self in relation to others, and avoidance and withdrawal behaviors” (Van Vliet, 2008, p.237). Avoidance behaviors often rationalize or minimize the shame experience. Withdrawal behaviors include isolation and not disclosing shame because of a fear of judgment or rejection.

### **Shame Resilience**

Shame is an inevitable and universal component of human experience, but is experienced at different rates and intensities. Shame resiliency aims to cope with shame, rather than eliminate it. Research highlights the distinction that the opposite of experiencing shame is experiencing empathy (Brown, 2006). Wiseman (1996) identified empathy as having four components: “seeing the world as others see it, being non-judgmental, understanding another’s feelings, and communication of understanding” (p.1165). Wiseman (1996) and Brown (2006) both recognized the healing power of empathy, which is often an interpersonal process.

Shame Resilience Theory (SRT) developed by Brown (2006) conceptualized the process of shame resiliency. Shame resilience is “increasing the opportunities to experience empathy by increasing connection, power, and freedom and decreasing feelings of being trapped, powerless, and isolated” (p.47). SRT points to socio-cultural expectations as the main culprit for maintaining shame. This research found that self-empathy and empathy received from another person both contributed to an increase in connection and power. By connecting with others

through shared experiences and mutual support, empathy further deconstructs these expectations and reduces feelings of shame (Brown, 2006).

Shame resilience theory (SRT) is presented as a continuum fluctuating on an individual's acknowledgement of personal vulnerabilities, level of critical awareness, reaching out to others, and "speaking shame" (Brown, 2006, p.47-48). Shame resilience can be strengthened through the practice of these skills. Being aware of situations, events, and perceptions that make one feel exposed and vulnerable increase the chance of one understanding their experience and getting the support they need. Understanding shame and what triggers shame leads to increased awareness and is the first step of shame resilience. Critical awareness involves the process of understanding personal experiences of shame through a socio-cultural lens, which normalizes the experience. Shame negatively perseveres without a deep examination of our shame experiences. Moreover, reaching out to others and sharing shame stories promotes shame resilience and builds connections. Not reaching out to others, leads to isolation and can be detrimental to the shame experience. Lastly, "speaking shame" is essential to promoting shame resilience because it allows for expression of emotions and decreases the chances becoming shut down from shame (Brown, 2006; Brown, 2007).

While Brown (2006) views shame resiliency on an ever-present continuum, another shame resilience model focuses on repairing the self after shame has occurred. Van Vliet (2008) describes the shame resilience as "rebuilding the self" through five principal processes: connecting, refocusing, accepting, understanding, and resisting" (p.238). One can defy isolation and withdrawal through connecting with others. This involves finding allies and sources of support, socializing and engaging in activities, talking with others about the shame experience, engaging in counseling, reconnecting with religion or spirituality, and repairing relationships that

were compromised from the shame experience. Refocusing involves “shifting priorities, focusing on the positive, working on self-improvement, reducing negativity, and taking action to address shame” (Van Vliet, 2008, p.239). Acceptance incorporates non-judgmentally accepting the responsibility for the feelings and actions involved in the shame experience. Additionally, understanding is “the continual attempts to make sense of the shame event by explaining why it occurred” (Van Vliet, 2008, p.241). This involves investigating outside influences that influenced the shame experience such as other people, outside stressors, past personal experiences, and broader sociocultural influences and norms. Resisting is an approach to prevent and protect against future shame reactions through rejecting negative judgments, asserting oneself, and challenging others” (Van Vliet, 2008, p. 241).

### **Clinical Supervision**

The word *supervision* “derives from the Latin *super* (over) and *videre* (to watch, to see)” (Kadushin & Harkness, 2002, p. 18). A supervisor is an individual who oversees and watches over their supervisee due to the supervisor’s ultimate responsibility for the quality of the work their supervisees produce. In order to explore shame within the supervisory relationship, it is helpful to have a clear definition of clinical supervision within the social work field. Munson (2002) defines clinical supervision as:

“Clinical supervision is an interactional process in which a supervisor has been assigned or designated to assist in and direct the practice of supervisees in the areas of teaching, administration, and helping. The supervisees are graduates of accredited schools of social work who are engaged in practice that assists people to overcome physical, financial, social, or psychological disruptions in functioning through individual, group, or family intervention methods” (p.10).

This definition reiterates that clinical supervision serves the purpose of supporting the supervisee so that they are best able to help the clients they serve. Clinical supervision serves the purpose of providing supervisees with practice guidelines and rules to use when confronted with situations in practice. Kaiser (1992) specifies the importance of adapting clinical supervision and practice guidelines to the cultural context of the supervisee or client. While many models of clinical supervision have developed a framework of guidelines, a one-size-fits-all approach can be detrimental to supervisees and perpetuate negative stereotypes (Kaiser, 1992). Clinical supervision is the avenue in which faith can be restored in supervisees through discussion of their personal struggles and concerns. In turn, this process can restore faith in the clients the supervisee serves (Munson, 2002).

### **Functions of Clinical Supervision**

Clinical supervision has three universal functions: support, education, and administration (Kadushin & Harkness, 2002). These functions serve to increase supervisees' skills to do effective clinical work and increase their confidence. A function of clinical supervision is to support the supervisee in regards to their therapeutic work and clinical learning leading to competent service to clients (Alonso & Rutan, 1988; Kaiser, 1992). Munson (2002) argues that good clinical social work supervision involves administrative functions such as "a formal and structured format, regular meetings, consistent style and approach of supervision, and is case oriented at all times" (p.12). This structure within clinical supervision allows for optimal educational learning for supervisees. The educational function of supervision is concerned with "teaching the worker what he or she needs to know to do the job and helping his or her to learn it" (Kadushin & Harkness, 2002, p. 129). The supervisor is responsible for equipping supervisees with the effective clinical tool and techniques they will need in their future as social workers.

This includes directly teaching skills, but also involves guiding supervisees to their own individualized approaches or solutions.

### **Models of Social Work Supervision**

Social work supervisors need a model of supervision to provide clear direction within their supervisory work. Because of the complex and stressful nature of the problems that clients face, social work supervisees and supervisors often process challenging and emotionally charged cases during supervision time. Having a clear model or framework of supervision provides a foundation that is easy to follow. There are several different models of supervision available. This research is grounded in two models: the interactional approach, which places significant emphasis on the supervisee-supervisor relationship, and view the supervisory process as developmental (Barker, Exum, & Tyler, 2002; Shulman, 2010).

**The interactional approach.** A well-known supervision model developed by Shulman (2010) is the interactional approach to supervision (Shulman, 2010). The “working relationship” is central to this model of supervision, and denotes the parallel process that occurs, whereby the relationship between supervisor and supervisee/worker reflects the relationship between the supervisee/ worker and client in practice (Shulman, 2010). Rapport, trust, and caring are three elements that determine the strength of the working alliance regardless if it is between supervisor and supervisee or between supervisee and client. Rapport is defined as “the general ability to get along well with the supervisor.” Trust is “the ability of the worker to be open with the supervisor and to share mistakes and failures, as well as successes.” Caring is defined as “the perception of the supervisee that the supervisor is trying to help, and cares about the worker as well as the clients” (Shulman, 2010, p.15). These dimensions of the working relationship are central to the foundation of interactional approach. Another key aspect of this approach is considering



supervision a developmental process, which is continually growing and changing based on the needs of the supervisee. Shulman (2010) outlines this developmental process through three phases of supervision, which mirror the therapeutic relationship: the beginning phase, the middle phase or work stage, and the ending phase. The interactional approach to supervision is a central approach to supervision. (Munson, 2002; Kadushin & Harkness, 2002).

**Kaiser's conceptual model of supervision.** Kaiser (1992) describes important concepts of the supervisory relationship within the conceptual model of supervision. She poses that power and authority, shared meaning, and trust are importance aspects of a positive supervisory relationship. The foundation of this model considers the supervisory relationship as a piece of a larger context, which includes the setting where the supervisory process promotes accountability which leads to the ultimate goal of supervision as providing competent service to clients. (Kaiser, 1992).

### **The Development of Shame Within Supervisees**

Shame can develop in supervisees from different avenues, as a result of interactions with clients, the supervisory relationship, and the supervisee's internal struggle. Supervisee shame may be experienced in response to taking on the client's emotional state (transference) or being triggered personally by a client (countertransference). Shame can also develop in relation to the supervisory relationship, most commonly in relation to the quality of their clinical work (Chorinsky, 2003). Shame can also develop related to "feedback, to how the supervisor might perceive or judge the supervisee, to cultural issues, to presenting tapes to the supervisor, to power differential, to the supervisor's style or specific supervisor qualities, or to something the supervisee did or did not do in supervision" (Chorinsky, 2003, p. 94). Lastly, shame can develop out of supervisees' negative self-perceptions and judgments of themselves (Chorinsky, 2003).

Chorinsky (2003) found that experiencing shame negatively impacted supervisee's openness in supervision. Supervisees experiencing shame desired less time talking with their supervisor and became more closed-off and self-protective.

**Parallel Process.** Clients often seek psychotherapy due to underlying feelings of shame, and additionally may experience shame as part of seeking help for their emotional struggles. Many clients seek out the help of a social worker to deal with their personal feelings of shame (Dearing & Tangney, 2011). Social workers need to be knowledgeable in defining and explaining shame to the clients they work with and also have an idea of how to effectively address shame within their clients. Not having a clear understanding of how to approach shame with clients can lead to a social worker developing their own shame in their ability to care for the client. As the interactional model of supervision implies, shame can permeate through parallel process (Shulman, 2010). For example, as the client struggles with feelings of shame, and the social worker feels stuck in addressing the shame in their client, the social worker themselves may take on shame and carry it into their relationship with their supervisor.

### **Supervisee Reactions to Shame within Supervision**

There are several ways that shame is expressed within the supervisory relationship. In fact, supervisees have varying levels of awareness and acknowledgement of the shame they bring into supervision. When supervisees recognize that they are experiencing shame, they may choose to hide their shame and deal with these feelings on their own, or supervisees may choose to courageously disclose their shame to their supervisor regardless of their fear of being negatively evaluated (Hahn, 2001). When the latter situation occurs, the supervisee has the opportunity to collaboratively explore and find positive ways to cope with their feelings of shame with the help of their supervisor. Chorinsky (2003) found that the majority of intern supervisees openly

discussed shame with their supervisors, and this was found to have a positive effect on supervisee's openness. However, supervisees may automatically react to feelings of shame as a way to protect themselves during a vulnerable state. These reactions are often innate and unconscious (Hahn, 2001).

What do these defensive reactions look like within the supervisory relationship?

Nathanson (1992) recognized four common defensive reactions to shame, which are: withdrawal, avoidance, attack on self, and attack on others. These automatic reactions to shame are good identifiers to supervisors that a supervisee may be dealing with feelings of shame. Supervisors need to be aware of these observable actions in order to help their supervisees identify and deal with shame.

*Withdrawal* is the most common reaction to shame. Withdrawal reactions are "passive attempts to minimize shame" (Hahn, 2001, p.276). Supervisees often pull-away or distance themselves from their supervisor when experiencing shame in an effort to decrease their emotional reactions (Chorinsky, 2003). Van Vliet (2008) describes withdrawal reactions as retreating or isolating fueled by fear or rejection or criticism. Withdrawing decreases access to support and increases feelings of shame.

*Avoidance* reactions are "relatively active efforts to prevent exposure and condemnation" (Hahn, 2001, p. 276) Avoidance reactions manifest as hyper vigilance and hypersensitivity which serve to prevent feelings of vulnerability and inadequacy (Nathanson, 1994). Often, it is difficult for supervisors to identify avoidance reactions in their supervisees because they are often difficult to recognize unless they are severe. Avoidance reactions often serve to take the attention off of the supervisee. Some avoidance reactions can be beneficial to the supervisee such as compulsiveness, diligence, and perfectionism, which can aid in academic learning and

conceptualizations of clients. However, these reactions become problematic when the supervisee avoids what they do not know, or fails to acknowledge they do not know enough about their client (Hahn, 2001).

*Attack on self* reactions occur on a continuum. On one end, the supervisee defers to the supervisor's expertise, and on the other, the supervisee displays excessive self-criticism (Hahn, 2001). As a supervisee gains skill and confidence, the supervisee can quite easily move away from the deference end of the continuum. However, self-criticism end of the continuum can be highly detrimental to supervisees, resulting in self-condemnation and repeated put-downs. Supervisees who utilize the attack on self shame reaction often become preoccupied with receiving their supervisor's approval which stems from their fear of losing connection with their supervisor (Hahn, 2001).

*Attack on others* reactions occur when a supervisee feels devalued or inadequate as a result from a disconnection with their supervisor. Supervisees feel disconnected when their supervisors fail to respond to their innate needs as a supervisee. Attacking others and attempting to regain power are commonly manifested through criticism, blaming, and non-verbal communication such as eyebrow raising. Specifically in supervision, a supervisee may become dismissive, critical of their clients, or condescending of their supervisor's suggestions (Hahn, 2001).

### **Shame: The Role of the Supervisor**

Supervision is an ideal setting to discuss feelings of shame if they arise within a supervisee. Speaking shame is an important piece of shame resiliency, and if the supervision relationship is a safe environment to discuss these self-conscious feelings, the opportunity should be seized. However, many social work supervisees do not discuss shame in supervision (Alonso,

1988). In fact Munson (2002) argues that a supervisee should only bring up personal issues as they relate to a particular client case, for the sake of keeping focused during supervision.

However, supervision is evolving into a space where personal insecurities, shame included, can be welcomed and openly discussed. If a supervisee feels an underlying feeling of inadequacy as a clinical social worker, their clinical supervisor who serves as their guide and mentor in their professional development needs to be aware of this fact regardless if it relates to a client.

Additionally, it is vital for supervisors to be aware of all the pieces that make up the supervisory relationship and how they may each be contributing to shame within the supervisee. These four pieces are: the client, the supervisee, the supervisor, and the environment/agency in which the supervisee is conducting their clinical training/practice (Alonso & Rutan, 1988).

From a psychodynamic perspective, when the supervisor fails to respond to a supervisee's needs or expectations, that supervisee makes sense of the experience by internalizing that they are not worthy or projecting the experience and discounting the supervisor which ruptures the relationship. The supervisor holds a difficult task of balancing unconditional support for the supervisee while providing clinical learning, which incorporates setting limits and appropriate interventions. This can be especially difficult during times of crises or when a supervisor assesses an aspect of the clinical environment to be dangerous. The result of these interactions during crises, will result in the supervisee's increased sense of loyalty from the supervisor, or a sense of betrayal (Alonso & Rutan, 1988).

Chorisky (2003) found three variables that contributed to a supervisee feeling their supervisor was not helpful in dealing with their shame. These contributing factors are the supervisor being unsupportive and not wanting to help the supervisee deal with their shame, negative qualities of the supervisor or the supervisory relationship that hinder coping with

shame, and supervisor directly contributing to their feelings of shame (Chorinsky, 2003). Supervisor inflexibility, a supervisor making frequent judgments and criticisms of the supervisee (Chorinsky, 2003), and a perceived lack of empathy and dismissiveness of supervisor (Grey et al., 2001) have been associated with supervisee shame.

Timing is important in discussing shame with supervisees. It can be embarrassing, painful, and even damaging for supervisors to prematurely confront shameful reactions in supervisees (Hahn, 2001). However, there are specific instances where a supervisor may need to intervene immediately. This may be the case when a supervisee's shame reaction is directly damaging to a client (Hahn, 2001). These confrontations require great care and sensitivity because Samec (1995) found that a supervisor's negative evaluations could be traumatic for supervisees, which can lead to further avoidance or withdrawal reactions. Supervisors need to be mindful of how their words and behaviors can contribute to supervisees' shame reactions.

### **Ways a Supervisor Can Promote Shame Resilience in Supervisees**

The research outlines many ways that supervisors can promote shame resilience in their supervisees. Awareness and maintenance of the supervisory relationship, acknowledging power and authority, supervisory techniques and personality, administrative duties, valuing diversity, feedback, self-disclosure, increasing self-esteem, and parallel process are contributing factors to promoting shame resilience in supervisees.

**Awareness of the relationship.** Supervisors can help reduce shame in their supervisees by being keenly aware of what is happening within the supervisory relationship. It is important to be mindful of the supervisory relationship and promote a comfortable and inviting space for open communication (Yourman, 2003). Alonso & Rutan (1988) suggest loyalty and consistent availability to the supervisee as pivotal to the supervisee's sense of security. Additionally,

attentiveness and flexibility have shown to be qualities in supervisors that promote a supervisee's likelihood of self-disclosing around shame (Yourman, 2003). A good relationship between supervisor and supervisee promotes trust, safety, support and openness in supervisees (Chorinsky, 2003). The first step of the supervisor is to build a relationship where the supervisee feels safe enough within the supervisory relationship to begin a discussion around sensitive subjects such as shame.

**Acknowledging power and authority.** Discussion of power differentials in the supervisory relationship may help the supervisee come to a healthy understanding of the supervisor's power. This can alleviate potential preoccupations of supervisors' ability to fail the supervisee (Hahn, 2001). It is important to recognize that a supervisee may fear being negatively evaluated by their supervisor after exposing their shame. Supervisors who respect their supervisees' vulnerability while simultaneously recognizing the power and authority they possess are more likely to promote shame resilience in their supervisees.

**Supervisor's techniques and personality.** Chorinsky (2003) found that a supervisor's qualities including their supervisory technique and personality affected supervisee's openness in supervision. Supervisors who are positive, personable, and show interest in getting to know their supervisees on a personal level promoted openness in supervisees.

**Administrative duties.** There are managerial strategies that social work supervisors can implement to reduce the likelihood that a supervisee will experience shame. One way is to manage the supervisee's caseload by regulating the severity and intensity of the clients they see. By providing the supervisee with a balanced caseload of challenging clients and clients whom the supervisee feels competent and successful, the supervisee strikes a healthy balance of clinical growth while also experiencing a sense of mastery. Supervisors, who encourage supervisees to

allot for non-client time during their workday and opportunity to observe the supervisor in practice, promote the values of reflection and gaining perspective. These insights can assist the supervisee in managing feelings of shame they may be experiencing (Alonso & Rutan, 1988).

**Value Diversity.** For a supervisee to develop their clinical skills, they need the opportunity to express their beliefs, opinions, and freely experiment with their clinical skills. (Alonso & Rutan, 1988). In order to acquire this learning opportunity, a supervisor must encourage differences in opinions. A supervisor whom can explicitly state that discussion of differences in opinions between supervisor and supervisee provides excellent learning opportunities promotes shame resilience (Yourman, 2003).

**Feedback.** Frequently asking for honest feedback regarding the supervision process and relationship promotes shame resilience. A supervisor must ask the supervisee how things are going for them, and directly ask for feedback on their satisfaction with the supervisory relationship. This helps open up the conversation when there may be some shame that has built up around the supervisory relationship (Yourman, 2003). During supervision, supervisors must also provide feedback to the supervisee. This can be a very shame-prone situation for a supervisee. Supervisors can promote active involvement and decrease the sense of helplessness when giving feedback during supervision by encouraging that the supervisee come prepared with an agenda and questions to process regarding their cases. This process helps engage the supervisee while simultaneously reduces shaming (Alonso & Rutan, 1988). Eliciting positive feedback to supervisees is another way supervisors can promote openness within the supervisory relationship and aid in reducing shame (Chorisky, 2003).

**Self Disclosure.** A supervisor 's self-disclosure has shown to promote satisfaction with the supervisory relationship in both supervisees and supervisors (Yourman, 2003). Furthermore,



a supervisor's disclosure of their embarrassments or difficulties in similar situations has been suggested for alleviating shame in supervision (Alonso & Rutan, 1988; Hahn, 2001).

**Increasing Self-Esteem.** One way of promoting shame resilience in supervisees is further developing supervisee self-esteem through empathy, normalizing, and validating. A supervisor can empathize with the supervisee through acknowledging the difficult position of the supervisee in feeling confident as a professional while still in the role of student in training (Hahn, 2001). Normalizing is another way that a supervisor can increase the supervisee's self-esteem. By normalizing hurdles in clinical learning and therapeutic treatment, the supervisee develops insight that their feelings are not uncommon and are even to be expected (Hahn, 2001). Validating is important to promoting shame resilience within the supervisee. A supervisor may validate a supervisee through encouragement of their work daily (Alonso & Rutan, 1988). A supervisor must remain sensitive of the individualized characteristics among supervisees, which may decrease their self-esteem, making them shame-prone (Doherty, 2005).

**Parallel Process.** The parallel process is an excellent tool that the supervisor can use to increase the supervisee's sense of security within the supervisory relationship. A supervisor whom expresses empathy in regards to the client situation is, simultaneously, supporting and expressing empathy towards the supervisee through parallel process. When a supervisor remains sensitive and respectful of a client situation regarding shame, that supervisee will feel a sense of support and comfort in their own feelings of shame (Alonso & Rutan, 1988).

The review of the literature surrounding shame within the supervisory relationship provided direction for this research question. This research asks: "How do clinical social work supervisors perceive to be effective in approaching shame in their supervisees, and how do they evaluate their effectiveness?"

### **Conceptual Framework**

Psychodynamic theory is the all-encompassing theoretical lens that I use to understand and interpret how shame manifests within social work supervisees and how social work supervisors approach shame. Psychodynamic theory recognizes the unconscious processes, which developed out of psychoanalytic theory by the founder of psychoanalysis, Sigmund Freud (1856-1939), in the late 19<sup>th</sup> century. Psychodynamic theory recognizes that psychological problems can occur when unconscious impulses or feelings accumulate and the individual is unable to express those impulses and feelings in a way that is satisfying to them and is also acceptable to society (Truscott, 2010).

As a conceptual framework, psychodynamic theory recognizes that human life is a continual balance of managing one's inner mind and outer environment, which are in constant conflict with one another (Forte, 2007). Psychodynamic theory also recognizes that early life experiences hold power in forming problems later in life. Additionally, early caregivers and interactions with these caregivers have a great influence on the person's development and ability to cope. However, psychodynamic theory holds that we have a natural inclination to adapt. This theory holds hope for overcoming challenges, but recognizes this may require help of others to strengthen our understanding of ourselves with the goal of functioning more optimally and adaptively. Truly knowing yourself through uncovering one's unconscious emotions allows one to have more energy to lead a meaningful life (Truscott, 2010).

Within psychodynamic theory, Erik Erikson developed the Model of Human Development, which identifies eight stages with presenting tasks, which are crucial to complete in achieving optimal human development. The model helps form the conceptualization of where shame comes from and that it can develop as the result of childhood experiences. The second

stage “Autonomy vs. Shame” is the vital stage in a child’s development where they develop the ability to self regulate their emotions and behaviors. A child develops feelings of freedom and self-confidence as they grow to not be fully dependent upon their caregiver/parent. However, feelings of self-consciousness may develop if the child’s caregiver is overprotective and doesn’t allow the child to gain a sense of autonomy. The child, then, develops shame as a result of not feeling competent in their ability to cope with their emotions and the world around them (Forte, 2007).

Self-psychology developed out of psychodynamic theory by Heinz Kohut (1913-1981). This theory strongly values how important the quality of the relationship with caregiver is in shaping human development (Truscott, 2010; Forte, 2007). The quality of the relationship and the availability caregiver provides a child with a sense of emotional growth, self-confidence, and tools to adapt (Cooper & Lesser, 2015). When a child has good experiences early on, the child is able to develop the skills needed to soothe and regulate themselves, but if the child does not have enough of these experiences, shame can manifest as a result of feeling ill equipped and self-conscious due to the failure to connect with caregiver (Cooper & Lesser, 2015).

Human beings are complex organisms that have individualized values, and needs. Additionally, we are social beings that long for connections with others and to feel accepted and have a sense of belonging. Because of this need to belong and be liked, we naturally may fear being vulnerable to others for fear of exposing our faults and not being accepted. We hide away our deepest secrets and insecurities. Then, when we feel exposed to the world, we experience shame and we further hide into our inner world and engage in negative self-talk, further perpetuating feelings of shame. Environments where individuals are regularly subject to

evaluation and criticism are naturally at high risk for developing shame (Cooper & Lesser, 2015).

## **Methodology**

### **Research Design**

The purpose of this study was to explore social work supervisors' experiences and perceptions of effective responses to shame within their clinical supervisees. A qualitative study was conducted using grounded theory methodology to investigate how social work supervisors define, identify, and acknowledge shame within their supervisees. This study also explored how social work supervisors evaluate their efforts in responding to supervisees' shame. Utilizing grounded theory methodology allowed a theory to emerge from the data through a continuous interaction between the inductive processes of data collection, data analysis, and theory development (Monette et. al, 2014). The retrieval of "rich data" with "thick descriptions" provided this study with an interpretive and subjective look at participants' experiences and perceptions (Charmaz, 2000). This study provided the opportunity for social work supervisors to contribute their knowledge and experiences with shame in supervision so that other social work professionals might learn and benefit from their experiences.

### **Sample**

For this study, 5 licensed, independent clinical social work (LICSW) supervisors from the Twin Cities metro area were interviewed. Participants held a valid social work license by the Minnesota Board of Social Work at the time of the interview. Participants were required to currently practice clinical social work and be providing social work service to clients. Participants were required to currently be providing individual clinical supervision to at least one supervisee. Participants had supervisees who were either a social worker or social work graduate

student receiving supervision as required for either licensure or completion of an internship as part of graduation requirements of an MSW program. Participants were required to have supervised a minimum of 10 social work supervisees within their career. Additionally, participants had to endorse an awareness of shame and have the ability to contribute to a discussion regarding the concept of shame within the supervisory relationship.

Exclusion criteria for this study included: not holding a valid social work license, not endorsing to provide social work services, or not identifying as a social worker. Participants were excluded from this study if they only currently provided group supervision. Participants whom were not credentialed to provide clinical supervision were deemed inappropriate for this study, and thus excluded from the sample.

### **Recruitment Strategy**

Participants were selected through a combination of purposive, convenience, and snowball sampling. Convenience sampling was utilized to recruit participants whom were readily available due to the difficulty of obtaining a whole sampling frame (Monette et. al, 2014). This sampling was also purposive in nature based on the knowledge that the participants would “best serve the purpose of the study” (Monette et. al, 2014, p. 148).

To recruit LICSW participants for this study, this researcher obtained a publically available email list of current LICSW supervisors from the Minnesota Chapter of National Association of Social Workers (NASW) website. LICSW participants were recruited through this researcher sending an email to all the contacts on the NASW list, inviting them to participate in this research study (See Appendix A). The email that was sent to potential participants included the purpose of the study, the criterion for participating in the study, the researcher's contact information, affiliation with University of St. Thomas/St. Catherine University, the voluntary

nature of the study, and contact information for the St. Catherine University Institutional Review Board.

This research also obtained an email contact list of LICSW supervisors from a committee member. This researcher contacted the LICSW supervisors directly via email, inviting them to participate in the study (See Appendix A) and requested interested participants to contact this researcher directly via email or telephone if they were interested in participating or to ask further questions about the study. By contacting the participants directly, this researcher decreased any possibility of coercion due to the committee member providing the initial email contact list.

Snowball sampling was also utilized to recruit participants for this study. This researcher attempted to request potential participants from the participants who participated in the study. However, this method of recruitment did not yield any additional participants for this study.

This researcher obtained a publically available phone contact list of current LICSW supervisors from the Minnesota Society for Clinical Social Work website. This researcher recruited LICSW participants by contacting potential participants via phone, inviting them to participate in this research study (See Appendix B). The researcher included information regarding the purpose of the study, the criterion for participating in the study, the researcher's contact information, affiliation with University of St. Thomas/St. Catherine University, the voluntary nature of the study, and contact information for the St. Catherine University Institutional Review Board.

When potential participants responded to a recruitment email or phone call, the researcher provided a more detailed explanation of the study, a copy of the interview questions, and the consent form via email.

This researcher gained knowledge from the data collected from the participant interviews in order to better understand how social work supervisors respond to shame within their supervisees. This knowledge strives to better support and educates social work supervisors and supervisees on how to deal with the experience of shame.

### **Protection of Human Participants**

Recruitment and data collection for this research study did not begin until this research study received approval by the Institutional Review Board at St. Catherine University. Participants of the study were informed of how this researcher planned to maintain the participants' confidentiality within the consent form. This researcher wrote the consent form based on a template provided by the St. Catherine University (See Appendix C). Participants were informed that their participation in this study was voluntary and they could elect to skip questions or withdrawal from the study at any time without repercussions. This researcher assessed if the participant understood what they are being asked to do by asking all participants the open-ended question, "What am I asking you to do if you choose to participate in this study?" as well as "What will you do if you decide you would like to withdraw from the study?" This researcher and the participants reviewed and signed the informed consent immediately before beginning the interview questioning.

Participants of the study were protected as their identities remained confidential, and any identifying characteristics of participants were removed from the data. Interviews were conducted in a private room (i.e. office room, conference room) or other conveniently located space of the participant's choosing (i.e. lobby) at the participant's place of employment or another public location (i.e. library). The locations for data collection were free from distraction and maintained the participants' confidentiality. Interviews were audio recorded to document the

interview and allowed only this researcher to review the recording for purpose of the study. The audio recordings were stored in a password-protected file in the researcher's computer, ensuring no one else had access to the audio recordings. This researcher transcribed all interviews from audio format to written transcriptions. Written transcriptions of the interviews were stored in a password-protected file in the researcher's computer, and printed written transcriptions were stored in the researcher's locked filing cabinet at the researcher's home. Only this researcher had access to the locked filing cabinet, containing the data. Data were stored within this locked filing cabinet at all times except for when in use by this researcher. All consent forms were stored in a locked filing cabinet at the researcher's home. All emails sent between this researcher and participants were stored on the researcher's password-protected computer. The researcher was the only individual coding the data and destroyed the data after completion of this research study. On May 31, 2016, all consent forms, written transcripts in both electronic and printed form, emails sent to and from participants, and audio recording were permanently destroyed or deleted.

### **Data Collection Instrument and Process**

This research study utilized a semi-structured interview, which contained 12 primary, open-ended questions and additional probing questions to collect the data, which aligned with qualitative research methodology (Monette et. al, 2014). These interview questions were carefully selected after an extensive review of the themes found in the literature surrounding shame within supervision (See Appendix D). Qualitative interviews allowed this researcher to explore LICSW supervisors' rich and subjective experiences and perceptions of shame in the context of the supervisory relationship. Because of the interpretive nature of the questions asked, qualitative interviews precisely captured the individual perspectives of the participants. This



researcher immersed herself into the participants' experiences and perceptions in order to gather a full understanding of the data (Monette et. al, 2014).

The interview questions (Appendix C) prompted the participants to share their perceptions and experiences regarding shame within the context of the supervisory relationship. The questions began with obtaining demographic information (e.g., *area of practice, years of experience with clinical supervision*). Specifically, this researcher asked participants to define shame, and explored their experiences with responding to shame in the supervisees they supervise. This researcher asked how participants identify and respond to shame within their supervisees (e.g., *How do you detect shame within your supervisees?*). Also, participants were asked to share their opinions on how a workplace can help or hinder in approaching shame (e.g., *How does the agency or place of employment influence your ability to respond to shame in supervisees?*). Participants were also asked if they feel their own feelings of shame may influence their ability to respond to supervisees' shame reactions (e.g., *How does the management of your own shame influence your ability to respond to supervisees' shame?*). Lastly, this researcher inquired about participants' methods of evaluating their effectiveness with addressing supervisee shame (e.g., *How do you evaluate the effectiveness of your approaches to addressing supervisee shame?*) (See Appendix C). The use of additional probes were utilized based on the direction of the data being collected (Monette et. al, 2014).

The length of the interviews conducted ranged from 35-45 minutes, which included time to review and sign the consent form and respond to the interview questions. Upon completion of the interview, this researcher debriefed with participants by exploring their experience of the interview. This researcher also reassured the participants of maintaining confidentiality of the

data. Participants in this study were not financially compensated for their participation in this study.

### **Data Analysis**

A phenomenological approach was applied to the data analysis. This was the appropriate approach based on the purpose of the research study to understand the phenomenon of shame within the supervisory relationship from the social work supervisor's point of view (Monette et. al, 2014). This researcher utilized open coding to develop initial codes; no start codes were used. A list of commonly reoccurring phrases and terms appearing within the data formed "clusters of meaning" (Creswell, 2013). Data were reviewed several times to check for manifest as well as latent content. The codes that emerged from the data were categorized into dominant and sub themes as appropriate (Monette et. al, 2014). Codes that appeared in two or more interviews were considered a theme or sub-theme. In line with phenomenological data analysis, this researcher included reflective comments as they contribute to the data analysis and discussion of findings (Creswell, 2013).

### **Findings**

This study sought to answer the following research questions: "What approaches do clinical social work supervisors perceive to be effective in responding to shame within their supervisees?" and "How do clinical social work supervisors evaluate the effectiveness of their strategies in coping with supervisee shame?" Seven themes emerged in the data as to how clinical social work supervisors approach shame with their supervisees through the interpersonal process of supervision.

**Participants**

The sample included five participants (N=5). All five participants identified as female, LICSW clinical supervisors who currently practice clinical social work and provide clinical supervision. The study collected demographic information on all participants in the categories of area of practice, training, and professional experience. A snapshot of the demographics can be viewed in Table 1.

**Area of Practice.** Three participants identified their area of practice as outpatient mental health, which included community mental health, private practice, and psychotherapy. Of the participants who identified their area of practice as outpatient mental health, two identified trauma as an area of expertise in their work and one identified as a psychoanalyst. One participant identified their area of practice as school social work. The last participant identified her area of practice as hospital social work, which involves case management and advanced care planning.

**Training.** All five participants identified receiving training and ongoing continuing education requirements to provide clinical supervision. One participant indicated receiving an additional half-year of training in clinical supervision. Furthermore, two of the participants had experience teaching courses at the university level in clinical social work supervision or field seminar.

**Professional Experience.** The participants' years of experience in practicing social work ranged from 14-50 years, with a mean of 28.6 years. The participants' years of providing clinical supervision ranged from 4-47 years, with a mean of 21.2 years. In addition, the total number of supervisees supervised throughout participants' career ranged from 17-300 supervisees, with a mean of 95.4 supervisees; however, four of the participants expressed uncertainty and difficulty

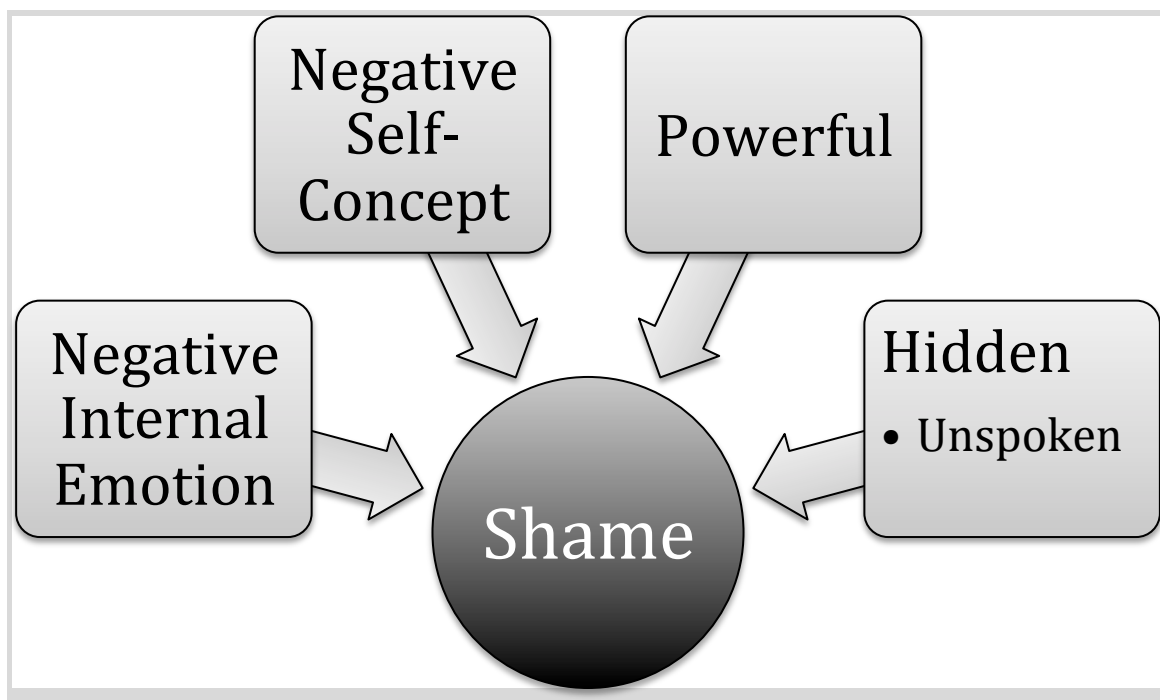
in approximating the amount of supervisees that they had supervised. One participant, who also reported the lowest amount of supervisees, gave a confident response in her supervisee count, identifying 17 supervisees.

Table 1: Participant demographics					
Participant	1	2	3	4	5
Area of practice	School Social Work	Outpatient Mental Health	Outpatient Mental Health	Hospital Social Work	Outpatient Mental Health
Additional Focus		Trauma	Psychoanalysis		Trauma
Additional training of experience	No	Taught Supervision Course	Additional ½ year training	Taught Field Seminar	No
Years of SW practice	17	50	37	14	25
Years of supervision practice	10	47	27	4	18
Number of supervisees	30	300	30	17	100

**Participants' Understanding of Shame.** This study found that shame often surfaced within the supervisory relationship. Four of the five participants reported that shame was something they regularly encounter within their supervisees. One participant reported that she “sees very little true shame in her supervisees” but reported supervisees struggled with “feeling guilty” regularly. Participants recognized that shame is a normal emotion to experience as a beginning social worker and have come to expect it in supervision. This study found that being in a learning role, new social workers are vulnerable to feelings of insecurity. One participant spoke to this phenomenon directly: “its very normal as a new therapist because it kind of takes us back to being a kid, and a little kid where we feel incompetent half the time because we are small and we are just learning to be able to find our way.”

Participants described shame as a negative internal emotion, a negative self-concept, powerful, and hidden. This construct of shame is illustrated in Figure 1 below. Participants described shame as “the elephant in the room” meaning it is a powerful and negative internal emotion or self-concept that is rarely talked about and “thrives in silence.” One participant, however, explained shame differently: her description of shame was “feeling bad about something you did because of a negative intent or recklessness.”

Figure 1: Participants' Concept of Shame



Four participants mentioned mental health concepts such as ADHD, suicide, anorexia, anxiety, trauma, and personality disorders when providing examples of shame in supervision. These concepts were mentioned either as the supervisee or the supervisee's clients personally experiencing these mental health challenges, or both. Some participants described supervisees who either currently or previously struggled with mental health concerns. Other participants were referenced a supervisee's client who had mental health concerns.

The data indicated that shame in supervisees is triggered by something in their practice with clients, something during supervision, or something else, personal to the supervisee. One participant illustrated how a supervisee might be shame triggered by a client:

Or else it is coming up as they share information about their patient or their client because they don't feel good about what they have done or their patient is really mad at them for something or another is telling them they are a terrible therapist, which people do. Which doesn't mean they are.

Participants furthermore described that they detected shame by observing their supervisees. For example, participants reported observing shame was observed in supervisees as: "looking afraid," "seeing it in their eyes," "their body shrinking or withdrawing," and "inability to put words together." Two participants noted shame can lead to a supervisee "feeling discouraged about their work." Two participants also reported shame causes ruptures in communication where the supervisee doesn't communicate openly with the supervisor about things they should be. Three participants reported a repeated theme discussed in supervision could be indicative of shame. For example, when a supervisee continues to bring up a certain area of their practice or issue they get "stuck on." Participants indicated this could mean they are experiencing shame.

**Supervision Purpose.** All participants reported that a purpose of supervision is to guide and mentor in the development of supervisees. Three participants reported the purpose of supervision as providing good service to clients. Four participants reported ensuring competent and ethical social work practice as a purpose of supervision. Please see Figure 2 below for an illustration of participants' reports on the purpose of supervision.

Figure 2: Participants' Responses to the Purpose of Supervision



**Supervision Style.** Participants described their supervisory styles as flexible, individualized, somewhat structured, and collaborative. These supervisory styles were categories that emerged directly through the coding and analysis of the data; no previously established categories of supervision style were utilized. Three participants explained their style as flexible with statements such as “go with the flow,” “laid back, not rigid,” and “relaxed.” Four participants reported their style as individualized to “meet the needs of the supervisee.” Additionally, three participants described their supervision style as somewhat structured, including a written agenda and regular planned meetings. Three participants reported having a collaborative style where the supervisee and supervisor work together in contributing to the supervision process, yet, while collaborative, this style is ultimately led by the supervisee. In addition, three participants reported that supervision is a reciprocal learning process, meaning that both the supervisee and supervisor learn from one another in the process. Please see Table 2 below for an overview of participants’ responses to supervision style.

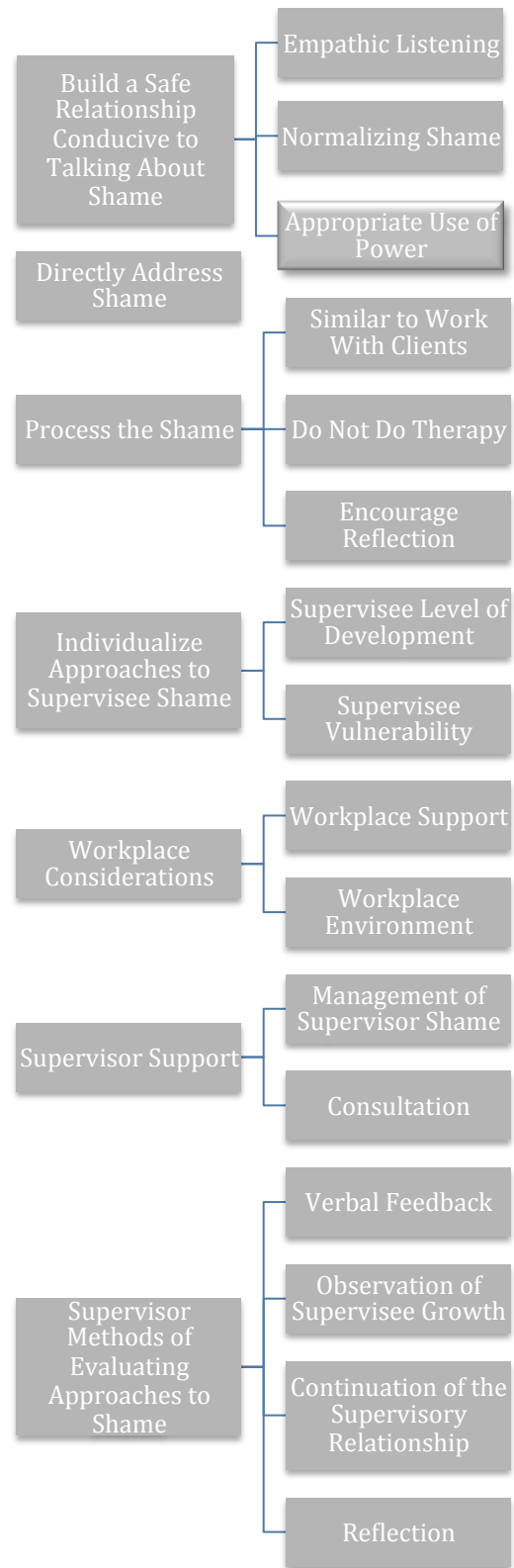
Table 2: Participants' Responses to Supervision Style					
Participant	1	2	3	4	5
Flexible	X			X	X
Individualized	X	X	X	X	X
Somewhat Structured		X	X	X	
Collaborative		X	X		X

### **Social Work Supervisors' Responses to Shame in Supervision**

Seven themes emerged in the data regarding social work supervisors' responses to shame in supervision. Participants identified the following themes: building a safe relationship conducive to talking about shame, directly addressing the shame, processing the shame, individualized approaches to supervisee shame, workplace considerations, supervisor support, and methods of evaluating approaches to shame. The following themes and their respective sub-themes are outlined in Figure 3 below.



Figure 3: Themes Regarding Social Work Supervisors' Responses to Shame in Supervision



**Build a Safe Relationship Conducive to Talking About Shame**

All participants commented on how important it is to have a solid supervision relationship based on safety, trust, and empathy in order for supervisees to feel comfortable in openly communicating about their feelings of shame. Participants reported that it takes time to develop safety and trust in the supervisory relationship because of the innate power differential between supervisor and supervisee. Participants reported that with time the relationship grows, and identified three ways supervisors can encourage positive growth in the supervisory relationship and, ultimately, allowing the supervisee to feel more comfortable in talking about shame: empathic listening, normalizing shame, and appropriate use of power.

**Empathic listening.** Empathic listening, or simply “listening to supervisees with compassion and empathy” while “not trying to necessarily fix it” was reported by three participants as a way to approach shame and also how to develop a good relationship with a supervisee in general. One participant explained this process as “being a caring person.”

**Normalizing Shame.** All participants reported normalizing shame as a way they approach supervisee shame. Participants explained normalizing shame as helping the supervisee understand that shame is “something we all feel at times” and reminding supervisees that shame is a “normal experience as a new therapist.” Four participants reported self-disclosure as a method of normalizing shame for supervisees. Self-disclosure is a way of “joining and not judging” the supervisee while simultaneously framing shame as a “normal experience.” One participant reflected on her use of self-disclosure to normalize supervisee shame: “Sometimes self disclosure can be helpful. I can say, ‘I remember when I was starting out, and I did this or that, and I was really paralyzed by feeling inadequate and now I might call that shame,’ I maybe didn’t know enough to call it that then.”

**Appropriate Use of Power.** Three of the participants acknowledged the inherent power differential in the supervisory relationship. One participant reported, “The clinical supervisor holds power in the relationship and it is their responsibility to be aware of their power, not to abuse it or deny it.” One participant described a misuse of power as “blaming, scolding, labeling, and generalizing.” A participant described how supervisors have a responsibility to handle their power appropriately:

How a supervisor handles power is really important I think in terms of working with shame. Supervisors tend to either misuse it, or some people are good with power, but when there are problems, they either are too directive, or they deny that they have power, and we are just buddies here together.

### **Directly Address Shame**

All participants outlined approaches to shame that directly addressed and brought attention to shame. Participants illustrated that directly addressing shame is the first step in bringing shame into awareness in the supervisory relationship. Participants' responses for directly addressing shame included, “naming it,” “pointing it out,” “stating the specific worry,” and “saying what you observe.”

Three of the participants commented on the importance of addressing shame and that not addressing it can be harmful. Not addressing shame was described as “ignoring it.” Two participants further described the negative impact of ignoring shame. One participant stated, “I think the first thing is to not pretend its not there because shame thrives in silence, and I think that we don't want to say too much because that can make it feel bigger. But I think to say nothing is worse.” Another participant explained her desire to avoid talking about shame when

there is an issue, but ultimately, believes that it is more harmful to not address big issues such as shame.

### **Process the Shame**

All participants discussed talking about the shame as an approach they utilize with supervisees. Participants described processing shame as “exploring their emotions and working through it.” Participants described this as a collaborative process in which the supervisor “helps supervisees see what is going on rather than telling them.” One participant explained that processing shame often stems from discussing transference or countertransference issues:

I don't necessarily probe for it [shame] with supervisees, but on the other hand, I certainly ask questions about their work that get them to talk about it. You know, so I am not going for shame, but I want to know their work, and I want to know about the transference and countertransference. I want that to be on the table. So, I certainly do not hesitate to talk about whatever I think needs to be talked about. A lot of people start talking about [shame] as it relates to general countertransference that they are having with clients. I think as you talk about that, if you are open to talking about that, then that will lead to shame.

Participants moreover identified three considerations for processing supervisee shame: It is similar to work with clients; it is not doing therapy, and encouraging reflection.

**Similar to Work With Clients.** All participants utilized the analogy of “it is similar to work with clients” to describe the process of exploring and working through emotions. One participant named this process “looking to the affect.” The participant described this process as “identifying and figuring out how to contain emotions” and utilizes this process with supervisees and clients. She provided questions to pose to supervisees that “look to the affect”:

“Tell my about the [feeling] annoyance?”

What goes on in you when you are with this person?

What is your internal process?

**Do Not Do Therapy.** All participants noted the important distinction of “not doing therapy with supervisees.” Participants distinguished, for example, that all processing of supervisees’ emotions and approaches to shame in supervisees should be focused on how it is affecting their practice or work with clients. When a social work supervisor finds that supervision is heading into a direction of therapy, or they feel that the supervisee could benefit from individual psychotherapy, that supervisor may recommend they “talk to their therapist” or “find a therapist” to process any personal shame that is unrelated to their work as a social worker. They made the specific distinction that approaching shame is “similar to approaching work with clients” but again, that processing is always professionally focused.

**Encourage Reflection.** Three participants reported they encourage their supervisees to reflect on feelings of shame in order to increase their self-awareness and growth. One participant reported she asks, “How can you learn from this?” Another participant noted she encourages supervisees to reflect on the overall role of the social worker and the boundaries in the social worker/client relationship. This participant explored this topic with the following questions: “Whose goals are you working on, yours or the clients?” and “Are you working harder than the client?”

### **Individualized Approaches to Supervisee Shame**

All participants reported that it was important to customize the way you approach shame with supervisees based on “what the supervisee needs” and “where they are at.” Participants frequently prefaced their responses to interview questions with “Well, it depends” which

indicated an overarching theme of individualized approaches to supervisee shame. Participants reported that a supervisee's level of development and ability to be vulnerable frequently played a role in how and when they approached shame.

**Supervisee Level of Development.** Three participants reported their approaches to supervision and to approaching shame are individualized based on where the supervisee is in their own developmental process. One participant contrasted the differences in supervising a new social worker at the beginning and the end of the supervision relationship. The participant explained:

I have really seen people developmentally. When they are early in their practice I am more direct. I will be more directive, a little bit more concrete and focus a bit more behavioral. As they are growing and developing and nearing the end of their supervision, and ready for the 'apron strings' to be clipped, whether they are ready or not, then I sort of pull back a little bit.

**Supervisee Vulnerability.** Participants reported that individual differences in supervisees' abilities to be open to learning and vulnerable in supervision determined how or when they approached shame. One participant explained that if a supervisee showed difficulty in disclosing their work, then they might be more sensitive to that supervisee in approaching shame or they may "wait until we got further along in supervision" before discussing shame. A participant explained, "when supervisees are like sponges, in term of what they want to learn, they are someone I feel I could say something sooner to, if I thought there was something going on where I could say, 'Do you think this was anything to do with shame?' and they would say, 'Oh, could you tell me more about that?' So, it depends."

**Workplace Considerations**

Workplace Considerations emerged as a theme within the data. All participants commented that the supervisee's workplace is relevant to supervision and approaching shame within supervision. Participants identified two specific considerations within the workplace that have an effect on supervision: workplace support and workplace environment.

**Workplace Support.** Four participants reported that workplace support was a factor to consider when approaching shame in supervisees. Two participants reported that being the only social worker at your workplace could contribute to feelings of shame because of feeling "closed off" and not having support from other social work colleagues at your workplace. Three participants commented that having supervision at the workplace during "work hours" is helpful because it "makes space for it to be done" and "makes it easier to find the time and not be resentful of needing to stay late or travel outside of work" as opposed to seeking supervision independently outside of the workplace. One participant explained, "It is hard to do supervision when you are not in their agency because you don't know the environment or the players." In contrast, two participants responded they felt outside supervision was "easier because there are no obligations to the agency" as well as, "cleaner and more helpful in addressing shame." Four participants additionally commented on their workplaces' level of support towards the social work profession and clinical supervision. One participant reported she felt supported by her workplace because they provide "the minimum required supervision hours" during the workday. One participant commented, "I think they are really trying, the administration is really trying to understand social workers and supervision and all that kind of stuff, but they don't." One participant explained how an employer could be harmful to supervision:

If you are in an agency where its pretty closed off to emotional processing, you know, they are focused on the numbers and all that stuff, then, I think people feel they can't really do their work and grow, which includes doing their own processing and um, working through their own stuff, so they can better be available to clients. I think a lot of stuff happens sort of privately, that you know, agencies are not familiar with everything that is happening in supervision. And if they were, they probably wouldn't like it because they are, in my experience and as I listen to my supervisees, you know agencies are pretty focused on numbers and you know, bottom line, and they don't really want to know about professional emotional growth. That is my experience.

**Workplace Environment.** Four participants reported that the workplace environment could be helpful or harmful to supervisees' development. One participant reported that a "male competitive culture certainly contributes to shame and is a detriment." Another participant discussed how a workplace culture of positive reinforcement is beneficial to professional development. Two participants reported that when a workplace isn't functioning well, it could negatively impact staff morale.

### **Supervisor Support**

Supervisor support emerged as a theme within the data that supported addressing shame in supervisees. Management of supervisor shame and consultation surfaced as specific ways that supervisors receive support in approaching shame with their supervisees.

**Management of Supervisor Shame.** All participants reported they had experienced shame personally. Additionally, all participants reported that it was essential for supervisors to be aware of and manage their own shame in order to best serve their supervisees and clients. Moreover, participants reported that their own management of shame was found to be helpful in



knowing how to deal with shame in their supervisees. One participant, for instance, spoke to how the management of her own shame was a strength in her work and her ability to assist supervisees who experience shame: "Having personal experience with shame helps be more comfortable with helping supervisees with their shame." Participants explained this process of managing their shame as "being honest to myself about it," "being comfortable with it," and "not being ashamed of shame." Another participant illustrated the need for supervisors to manage their own shame in order to avoid harming others:

I think it is essential. I think that we need to become very friendly with our own shame and resolve it as much as we possibly can because otherwise we are going to pass it on to the next person and that's not good. Our job is to be in charge of our own shame so that we don't attack other people, because otherwise we will. If we can work through our own shame, then we can apologize for that, and we can own it. Otherwise, we can't because we are stuck in protection.

**Consultation.** Four participants utilized consultation with colleagues as a resource to discuss concerns about shame within their supervisees or as a place to discuss a supervisor's personal feelings of shame. Consultation was described by participants as either consulting individually with a supervisor/colleague or in a group consultation setting. One participant who regularly has attended a group peer consultation for the duration of her professional career stated the group was an opportunity to "help each other with our blind spots." She later went on to elaborate on how consultation helped her in approaching shame with supervisees:

It was the most helpful thing because we had permission to really ask the questions of someone. So you could come to an understanding of maybe your own blind spot and shame is a really big blind spot. So, that practice, that process of being tuned in, in a way

both to my own shame and to my colleagues shame in that consultation group, I think really helped me both to identify it in other people, but also to know what was helpful or not helpful.

Consultation was also found to be helpful in providing direction in handling a situation where a supervisee experienced shame. One participant commented that consultation helped her “get some help in sorting it out” which was most supportive to the supervisor and, ultimately, the supervisee as well.

### **Supervisor Methods of Evaluating Approaches to Shame**

All supervisors provided examples of ways they evaluate their work with their supervisees. Some of the methods involved specifically evaluating their approaches to shame. Sometimes participants' responses involved general ways of evaluating supervision. Participants indicated four methods of evaluation including: verbal feedback, observation, continued supervision, and reflection.

**Verbal Feedback.** All participants indicated that they utilize verbal feedback from their supervisees as a form of evaluation in supervision. The process of verbal feedback was described as “checking in” and “looking at the process of what comes up.” Participants explained this process is an opportunity to understand what the supervisee needs from supervision, including what they have found helpful and not helpful, and how the supervisor can adapt to meet the needs of the supervisee. Participants provided examples of the questions they would pose to supervisees in evaluating their supervision experience:

Are you getting what you need from supervision?

What else do you need from supervision?

Is this meeting your needs?

Am I [as your supervisor] engaged enough?

I want to hear some constructive criticism from you about how I am doing.

Am I spending too much time on this and not on this?

What is working? What do you need more or less of?

One participant explained their process of receiving feedback as “built in from the beginning.”

This participant prepares her supervisees by stating in the first session that she will be frequently asking about their experience.

Participants varied in their responses to how often they use verbal feedback. Three of five participants indicated they check-in with supervisees every couple months. One participant responded that she asks for feedback about supervision every month. Another participant responded that she asks for feedback every six months and reported a reason for the frequency of her feedback as, “it’s hard because there are so many things that we have to talk about.” Several of the participants indicated that they would check-in more frequently if something “wasn’t quite right.”

**Observation of Supervisee Growth.** Two participants reported observation of supervisee growth as a method of evaluating supervisees. A supervisee who demonstrates growth in confidence and skills was indicative to one participant as a sign that supervision was effective. One participant explained the process of observation as an evaluation method:

If I have someone [a supervisee] who has been really struggling and stuck, and they are progressing, and they are understanding more, and they are making more effective interventions, and the relationship with the client is moving again, that would be another way, I would say, that I would gauge my effectiveness.

Keeping records of supervision sessions was reported by one participant as a way of remembering what to “pay attention to” in supervisees. Reviewing these records of supervision aided the participant in noticing changes and growth in supervisees.

**Continuation of the Supervisory Relationship.** Two participants reported that a supervisee who “keeps seeing me” or “is still coming [to supervision]” is an indication that they are successfully managing shame in the supervisory relationship. One participant explains her process of this evaluation method: “Most of the people want to see keep seeing me, and I am assuming they wouldn’t if they felt shamed a lot because I sure wouldn’t. So, I think that sense of safety, I think I really do well with that” Another participant describes her long relationship with a supervisee who has experienced a lot of shame during their work together:

“I have known him for 18 years, and he is still coming to me for supervision and consultation, so I feel like I have developed good relationships with people, and they trust me, and I feel like I am fairly well respected.”

When evaluating shame in supervisees, these two participants reported that the continuation of the supervisory relationship was a sign that they had been successful in addressing supervisee shame. They attributed three elements, safety, trust, and respect, to the success of their supervisory relationships.

**Reflection.** Three participants conveyed that reflection was a mode of evaluating the effectiveness of approaches to dealing with shame. Two participants provided examples of situations where they said something “very shaming” during supervision. These two participants reported reflecting back on these situations has helped shape their current, more effective approaches to supervision. These participants report that reflection has helped them to be more aware of their supervisees and has shifted their supervision style to be more open and sensitive to

their supervisees. One participant reflected on an experience she encountered as a new social worker during supervision. Reflecting on her experience as a supervisee experiencing shame and how her supervisor at the time approached this has shaped the way she approaches shame currently with her supervisees and has formed her supervisory style as well. She stated:

I have been shamed in supervision by a supervisor and have not been able to get through it or work it out, and really not felt I had a place to go to sort it out. So, I know what its like to be on the other side of that, and it's a terrible feeling, shame. That [supervisor] had a very specific way that I was supposed to work, and, if I didn't use her words and do it exactly that way, then, I was doing it wrong. So, I think that has influenced tremendously my more openness to finding your way or someone else's way, and not saying this is the only way because that wasn't helpful to me because I am not her and she is not me.

Accordingly, participants shared that reflecting on past supervision experiences was helpful in shaping how they currently provide supervision.

Participants in this study explored the many different approaches supervisors utilize to respond to shame within their supervisees. Additionally, participants commented on ways that supervisors evaluate their approaches to supervisee shame and to supervision in general. The seven themes that emerged captured the unique experiences of the participants of this study by highlighting the similarities as well as the differences in their responses.

### **Discussion**

The purpose of this study was to gain knowledge about shame within the supervisory relationship from a social work perspective and to educate social work supervisors and supervisees about the concept of shame and the perceived best ways of approaching it in within supervision. The study found several concepts to be important to LICSW supervisors when

approaching shame in their supervisees: building a safe relationship conducive to talking about shame, directly addressing the shame, processing the shame, individualized approaches to supervisee shame, workplace considerations, supervisor support, and methods of evaluating approaches to shame. This study supported much of the current literature on shame in supervision, but new themes emerged as well. This section provides a discussion on the findings of this study and highlights the similarities between the current research in this area and the findings.

Generally speaking, the participants' concepts of shame and supervision were consistent with the definitions outlined in the literature review. Participants' viewed shame as a powerful, negative, and internal emotion that is often hidden within a negative self-concept. This definition is reflective of a definition by Brown (2006), "an intensely painful feeling or experience of believing we are flawed and therefore unworthy of acceptance and belonging" (p.45). Participants mostly talked about the negative effect of shame on the supervisee's development and sense of self worth. Although noted, most participants did not give lengthy responses to the negative effects that shame can have on supervisees' interpersonal relationships, which Tangney & Dearing (2002) highlight as one of the major effects of shame. Participants illustrated the negative effects shame can have on a supervisee's ability to do effective work with their clients, but this was mainly attributed to the supervisee's own negative internal process. This finding suggests that social work supervisors primarily view negative effects of shame on their supervisees in the form of an internal, negative self-concept. This study found, when a supervisor demonstrated an appropriate use of power in supervision, this contributed to a safe relationship. Hahn (2001) found directly discussing power differentials and the role of the supervisor during supervision led to alleviation of worry with supervisees. Both this study and the previous

literature suggest that acknowledging and demonstrating an appropriate use of power in supervision contributes to a safe relationship conducive to talking about vulnerable topics such as shame.

### **The Supervisory Relationship**

Building a safe relationship that promotes the discussion of shame was found to be one of the most essential steps in approaching shame in supervisees. Awareness and use of the supervisory relationship was indicated both in this study and in previous literature as ways that supervisors can build a good base to approaching shame in their supervisees. This study found that a supervisor's ability to build a strong relationship with their supervisees built on trust, safety, and empathy was a foundational approach to supervision and to dealing with supervisee shame. Promoting a comfortable relationship that promotes good communication as well as trust, safety, support, and openness was also indicated in previous literature (Alonso & Rutan, 1988; Yourman, 2003) and further corroborated by this study. This study found empathic listening, normalizing shame especially through appropriate use of self-disclosure, and not misusing power were ways to build a solid and safe supervisory relationship. These findings were consistent with previous research that self-disclosure promotes satisfaction within supervision (Yourman, 2003) as well as alleviates shame (Alonso & Rutan, 1988; Hahn, 2001).

### **Approaches to Shame**

This study found that social work supervisors view directly addressing shame as the first essential and necessary step in bringing shame into awareness in the supervisory relationship. The study found that ignoring shame in supervisees by not addressing it could be detrimental. The literature suggests that timing is important in addressing shame, and warrants that certain instances need immediate intervention; however, approaching shame prematurely can be

embarrassing and damaging for supervisees (Hahn, 2001). Another study suggests that at times addressing shame when the supervisee is not ready for it can be traumatic (Samec, 1995). In summing the findings of this study with previous research, supervisors should always acknowledge supervisee shame, but the timing of directly approaching the topic and the method of approaching will ideally vary based on the individualized needs of the supervisee and the situation. This is consistent with the finding of this study that effective approaches to supervisee shame strive to be individualized based on the development of the supervisee and their ability to be vulnerable. Individualized approaches to supervision and to supervisee shame were a major finding of this study that presented in multiple areas of the interview. This study diverged somewhat from Munson's (2002) conceptualization that supervisee's should only bring up personal feelings as they relate to a client case. Processing shame in supervisees in "how it relates to their work" and "how it is affecting their ability to do good work" was mentioned. However, many participants identified that supervision sometimes crosses that boundary and allows supervision to be a space to process "whatever comes up" as it relates to their professional development as a social worker, which often includes feelings of insecurity in their work as a new social worker.

### **Workplace Environment**

This study found that the workplace influences the development of shame in supervisees and affects how supervisors approach shame in supervisees as well. Alonso & Rutan (1988) found that the agency environment where a supervisee is conducting their clinical training is one of the four contributing factors to the supervisory relationship that may contribute to shame. This study found the workplace environment was a contributing factor to shame not only for new social workers in clinical training, but for seasoned social workers as well. Support within the



workplace for the social work supervisee and the workplace culture were found to be influential in the development of supervisee shame and in supervisor's ability to acknowledge and approach shame. Being the only social worker at the workplace was found to be detrimental in that it isolated that supervisee and provided a lack of support, especially for beginning social workers. There were conflicting responses to the benefits of a supervisee having their clinical supervisor on site at the workplace. Some supervisees felt it was "cleaner" and more effective in dealing with shame if the supervision occurred outside of the workplace. Others felt it was more convenient and essential in understanding all of the contributing factors that could influence supervisee shame, such as the workplace culture and other colleagues as well as management.

An interesting connection was made between participants' area of practice and their level of support within their workplace. Two of the participants indicated they work within larger systems, school and hospital settings. One of these participants indicated they felt highly supported in their work environment, because their workplace supported their supervision framework and understood as well as valued the field of social work and clinical supervision. The other participant indicated they felt their workplace did not understand social work or clinical supervision, although they had made attempts to. This data leads to the hypothesis: When working in a system, the workplace's ability to understand and recognize the value of social work and clinical supervision is important to the supervisor feeling supported in their role and affects their ability to do their work and provide clinical supervision. These findings on workplace considerations were new to this area of study and warrant further research in order to test this hypothesis.

**Supervisor Support**

Supervisor support in the form of managing personal shame and receiving consultation were found to be beneficial in a supervisor's ability to effectively approach supervisee shame. These were new findings that emerged that were not found in previous research on shame in supervision, and thus the validity of these findings would benefit from future research in this area.

**Evaluation Methods**

Methods of evaluating the effectiveness of supervisors' approaches to supervisee shame were found. Verbal feedback, reflection, observation of the supervisee's growth, as well as the continuation of the supervisory relationship were found as common evaluation methods supervisors utilize. Prior research indicated the use of feedback during supervision as a method of evaluating the overall process of supervision (Yourman, 2003). However, my study found supervisors often use feedback as a form of evaluating their approaches to shame. Supervisors may not directly ask about shame when asking for verbal feedback, but the feedback provided information as to ways the supervisor can improve the supervisory relationship or help meet the supervisee's needs, ultimately aiding in other approaches to reducing supervisee shame.

**Telling Their Story**

All participants approached the research wanting to tell their story. They told powerful recollections about their experiences as supervisors and their approaches to shame. At times and across all participants, responses to interview questions went off course in ways that were relevant but not directly answering the researcher's posed questions and in directions that the participants felt were rich in providing "their story" and "their experiences." This researcher concludes, then, that this topic of approaching shame in supervision is something that the

participants felt strongly about. The research process of talking about the “elephant in the room” as one participant described shame, quite possibly was one of the few times they had a confidential and professional platform to speak freely and uncensored about the phenomenon of shame in their supervisees, aside from their own professional consultation as noted in the findings of this study. However, it is this researcher’s opinion that even within the safe haven of consultation or supervision, these participants most likely did not fully explore this topic as they did in the interviews for this study.

### **Approaching Shame is Similar to Approaching Other Emotions in Supervision**

All of the participants either directly stated that approaching shame is similar to approaching other difficult emotions in clinical supervision or they reported using similar or identical strategies when approaching difficult emotions and when approaching shame specifically. For example, one participant responded that helpful approaches to shame were “similar to working with guilt, or any other feeling.” This same participant then went on to describe their process of responding to shame in supervisees, which was identical to how that participant responded to how they approach difficult emotions in their supervisees. Specific similar approaches that were mentioned were to “help the supervisee name their emotions,” “openly process their emotions,” and “work through their emotions.”

### **Appreciation For the Study**

All participants expressed an appreciation for the study and four participants felt this research was really important and vital to the field of social work and clinical supervision. One participant exclaimed their appreciation, stating:

I think the research you are doing is really important. I really do, I think it is just vital. I have been saying for many years, being a therapist is a dangerous profession, because we

can really help people, but we can really hurt people. I think it is the same with supervision. As a supervisor, it is my responsibility to be helping that person be the next generation of therapists because its not gonna be me, you know? Its gonna be you. If we can't deal with the shame between us, how is that person gonna be able to do that out there when they see their patients or they become supervisors. So, I just think your research is really important, and I am glad you are doing it.

### **Implications for Practice**

This study has direct implications for social work practice and social work supervision. It informs practicing social work supervisors on the perceived best ways to approach shame in their supervisees. This study also helps to serve as an educational guide for social work supervisees and supervisors about the common yet hidden experience of shame.

### **Implications for Research**

This study found several themes outlining social work supervisors perceived best ways of approaching shame in their supervisees, as well as other considerations and ways of evaluating their approaches. The results of this study were consistent with other research on shame in supervision within the field of psychology. However, this study provides additional findings regarding workplace considerations, supervisor support, and evaluation methods. Additionally, this study provides a social work perspective in this research area, which was necessary, as there was no prior research regarding shame within supervision specific to the field of social work. The findings of this study indicate that social work supervisors' approaches to supervisee shame are highly individualized to the supervisee's development and their ability to be vulnerable. In addition, approaching and processing shame was viewed as essential and outweighed ignoring shame. Future research is needed regarding how the workplace environment and the

management of supervisors' own personal shame affects their approaches to supervisee shame. Future research is also needed on how supervisors effectively evaluate their approaches to supervisee shame.

### **Strengths and Limitations**

This study has strengths and limitations based on the qualitative nature of the research design. A major strength of this study is in the descriptive and exploratory nature of qualitative research, which provides rich descriptions on the “powerfully hidden” phenomenon of exploring shame within clinical supervision. The interview for this study were grounded in and informed by the previous literature surrounding shame and supervision. The semi-structured interview approach additionally allowed for flexibility throughout data collection and allowed the research to flow in the direction of the data. Furthermore, participants who were recruited for this study were required to have experience supervising a minimum of 10 supervisees, which provided valuable and experienced knowledge contributing to rich and insightful data for the study. By providing the participants with the interview questions prior to the interview, this provided more thoughtful and complete responses to the questions. Finally, the digital audio recording and transcripts provided increased validity to the study.

The limitations of this study were in the subjective nature of qualitative research. Researcher bias was impossible to avoid within this qualitative research because the researcher coded, interpreted, and analyzed the data through their own frame of reference and life experience (Monette et. al, 2014). During one of the participant interviews, the audio recording device malfunctioned, and this researcher was unable to obtain a full recording of the interview. This participant willingly offered to provide this researcher with a short summary of her responses to all of the interview questions via email. This data was included in the study.

However, due to circumstances some of the data from this interview was lost. One recruitment criterion of this study made recruitment of participants for this study more difficult. Many potential participants who expressed interest in the study were unable to participate because they did not meet the criteria of having experience supervising a minimum of 10 supervisees throughout their career. This may have led to a smaller sample size than this researcher hoped to get for this study. The limited sample size of five participants warrants that the responses of this study were true to this sample, but cannot be generalized to the larger population of all social work supervisors. Additionally, the recruitment method of convenience, purposive sampling may be biased to the views of social work supervisors who associate with the National Association of Social Workers (NASW) and the Minnesota Society for Clinical Social Work, as all participants were recruited through these associations' publically available contact lists. Lastly, shame was conceptualized in many different ways depending on participants' experience and backgrounds, and this lead to decreased reliability within this study. However, capturing multiple perspectives contributed to a more nuanced understanding of how supervisors address the role of shame in the supervisory relationship.

## **Conclusion**

This qualitative study found that social work supervisors frequently encounter shame within their supervisees. Social work supervisors recognize that addressing shame in supervisees is multifaceted, yet essential to their role as a clinical supervisor. Social work supervisors feel that addressing shame directly and helping the supervisee process their shame as it relates to their work with clients and their professional development is superior to the alternative of ignoring it. Other factors such as workplace considerations, supervisor support, and evaluation methods were also found to be important in effectively approaching shame in social work

supervisees. Ultimately, the research highlighted that approaching shame in social work supervision is highly individualized based on the supervisee's developmental needs and their ability to be vulnerable.

Most importantly, this study gets the conversation started around shame. As one participant stated, "Shame is so powerful because it is hidden, and its not talked about." Clinical social work supervisors who are aware that new social work supervisees are vulnerable to feeling insecure and experiencing shame can help to guide and mentor their supervisees to feeling more confident and aid in their successful professional development. Helping social work supervisees learn to deal with shame also helps them provide good service to their clients. One participant made this point clear asking, "If we can't deal with shame in ourselves, how can we help clients deal with shame?" Ultimately, helping social work supervisees address their feelings of shame aids in the professional development of the social worker and, in doing so, improves overall service to clients.

## References

- Alonso, A., & Rutan, J. S. (1988). Shame and guilt in psychotherapy supervision. *Psychotherapy: Theory, Research, Practice, Training*, 25(4), 576-581.  
doi:10.1037/h0085384
- Averill, P. M., Diefenbach, G. J., Stanley, M. A., Breckenridge, J. K., & Lusby, B. (2002). Assessment of shame and guilt in a psychiatric sample: A comparison of two measures. *Personality and Individual Differences*, 32(8), 1365-1376. doi:10.1016/S0191-8869(01)00124-6
- Bridges, N. A. (1999). The role of supervision in managing intense affect and constructing boundaries in therapeutic relationships. *Journal of Sex Education & Therapy*, 24(4), 218-225. Retrieved from <http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com.ezproxy.stthomas.edu/login.aspx?direct=true&db=sih&AN=24647289&site=ehost-live>
- Brown, B. (2006). Shame resilience theory: A grounded theory study on women and shame. *Families in Society*, 87(1), 43; 43.
- Chorinsky, B. C. (2003). *The impact of shame on supervisee openness in psychotherapy supervision* (Psy.D.). Available from ProQuest Dissertations & Theses Global: Health & Medicine, ProQuest Dissertations & Theses Global: Social Sciences. (305262764). Retrieved from <http://search.proquest.com.ezproxy.stthomas.edu/docview/305262764?accountid=2687>



Cooper, M. G. & Lesser, J. G. (2008). *Clinical social work practice: An integrated approach*

(3rd ed.). Boston: Pearson Education, Inc. Ally and Bacon. ISBN -13: 978-0-205-54550-6/  
ISBN-10: 0-205-54550-5.

Dearing, R. L., Tangney, J. P., & American Psychological Association. (2011). *Shame in the therapy hour* (1st ed.). Washington, D.C.: American Psychological Association. Retrieved from <http://ezproxy.stthomas.edu/login?url=http://content.apa.org.ezproxy.stthomas.edu/books/2010-23092-000>

Doherty, E. J. (2006). *Role of Internalized Shame in Clinical Supervision.*,

Ferguson, T. J., & Crowley, S. L. (1997). Gender differences in the organization of guilt and shame. *Sex Roles*, 37(1), 19-44. doi:10.1023/A:1025684502616

Gibson, M. (2014). Social worker shame in child and family social work: Inadequacy, failure, and the struggle to practise humanely. *Journal of Social Work Practice*, 28(4), 417-431. doi:10.1080/02650533.2014.913237

Hahn, W. K. (2001). The experience of shame in psychotherapy supervision. *Psychotherapy: Theory, Research, Practice, Training*, 38(3), 272-282. doi:10.1037/0033-3204.38.3.272

Hemlick, L. M. (1997). *The role of shame in clinical supervision: Development of the shame in supervision instrument* (Ph.D.). Available from ProQuest Dissertations & Theses Global: Health & Medicine, ProQuest Dissertations & Theses Global: Social Sciences. (304371912). Retrieved

from <http://search.proquest.com.ezproxy.stthomas.edu/docview/304371912?accountid=2687>  
[9](#)

Jacobs, C. (1991). Violations of the supervisory relationship: An ethical and educational blind spot. *Social Work*, 36(2), 130-135. doi:10.1093/sw/36.2.130

Kadushin, A., & Harkness, D. (2002). *Supervision in social work* (4th ed.). New York: Columbia University Press.

Kaiser, T. L. (1997). *Supervisory relationships: Exploring the human element*. Pacific Grove, Calif.: Brooks/Cole Publishing.

Kaufman, G. (1980). *Shame, the power of caring*. Cambridge, Mass: Schenkman Pub. Co.

Ladany, N., Friedlander, M. L., & Nelson, M. L. (2005). *Critical events in psychotherapy supervision: An interpersonal approach* (1st ed.). Washington, D.C; Washington, DC: American Psychological Association. doi:10.1037/10958-000

Ladany, N., Friedlander, M. L., & Nelson, M. L. (2005). Toward an events-based understanding of the supervisory process. (pp. 3-21). Washington, DC, US: American Psychological Association. doi:10.1037/10958-001

Ladany, N., Klinger, R., & Kulp, L. (2011). Therapist shame: Implications for therapy and supervision. In R. L. Dearing J. P. Tangney (Ed.), (pp. 307-322). Washington, DC, US: American Psychological Association. doi:10.1037/12326-013

Leeming, D., & Boyle, M. (2004). Shame as a social phenomenon: A critical analysis of the concept of dispositional shame. *Psychology and Psychotherapy*, 77(Pt 3), 375.

Lewis, H. B. (1971). *Shame and guilt in neurosis*. New York: International Universities Press.

Lidmila, A. (1997). Shame, knowledge and modes of enquiry in supervision. *Supervision of psychotherapy and counselling: Making a place to think*. (pp. 35)

Lutwak, N., Panish, J., & Ferrari, J. (2003). Shame and guilt: Characterological vs. behavioral self-blame and their relationship to fear of intimacy. *Personality and Individual Differences*, 35(4), 909-916. doi:10.1016/S0191-8869(02)00307-0

Mizrahi, T., & Davis, L. E. (2008). *The encyclopedia of social work* (20th ed.). Oxford; New York: Oxford University Press. Retrieved from [http://stkate.summon.serialssolutions.com.ezproxy.stthomas.edu/2.0.0/link/0/eLvHCX\\_MwjV1NS8NAEB2kevBm1WK1xT31lrLJ7ubjLBbRm1ZELyHZ7EBpSKTa\\_-8MafohCjmFzQ7ZLMu-zLzMmwVQwVR6vzCBgDJWYR6gtFrbPMwyGWNmokIXNo-Q5c\\_v8-DxxTy\\_6o9dzSRbLixF6FO-brNqmLkgUOW66AS9CaEra3yfvC21lhWHGaYpoGPIJ6YgoW34hNhmU3in7VR7be6PCZ55xAP1w95XZ3YGPVYi9OHIVecwaoS04s2VmK2cmIj2Rr1aXsAtrbdgGaUt609Wg4gaRUOIC869uoTx7H5-9-DxkOmGtEnbGfrBAHpVXbkrEAX\\_wsREoZ9nWiLmjo8\\_97WJC21RJUMY\\_P2MIUx2E0nX1aLis57TtfVTlvCE7OaRH6ejjoZGdzQMg46Gkbz-7-Vv4LTJ0WDaYwTHSNvSjeHk63tJ3vgPTWyqWQ](http://stkate.summon.serialssolutions.com.ezproxy.stthomas.edu/2.0.0/link/0/eLvHCX_MwjV1NS8NAEB2kevBm1WK1xT31lrLJ7ubjLBbRm1ZELyHZ7EBpSKTa_-8MafohCjmFzQ7ZLMu-zLzMmwVQwVR6vzCBgDJWYR6gtFrbPMwyGWNmokIXNo-Q5c_v8-DxxTy_6o9dzSRbLixF6FO-brNqmLkgUOW66AS9CaEra3yfvC21lhWHGaYpoGPIJ6YgoW34hNhmU3in7VR7be6PCZ55xAP1w95XZ3YGPVYi9OHIVecwaoS04s2VmK2cmIj2Rr1aXsAtrbdgGaUt609Wg4gaRUOIC869uoTx7H5-9-DxkOmGtEnbGfrBAHpVXbkrEAX_wsREoZ9nWiLmjo8_97WJC21RJUMY_P2MIUx2E0nX1aLis57TtfVTlvCE7OaRH6ejjoZGdzQMg46Gkbz-7-Vv4LTJ0WDaYwTHSNvSjeHk63tJ3vgPTWyqWQ)

- Monette, D. R., Sullivan, T. J., 1944, DeJong, C. R., & Hilton, T., 1973. (2014). *Applied social research: A tool for the human services* (Ninth ed.). Belmont, CA: Brooks/Cole, Cengage Learning.
- Morrison, A. P. (2011). The psychodynamics of shame. In R. L. Dearing J. P. Tangney (Ed.), (pp. 23-43). Washington, DC, US: American Psychological Association.  
doi:10.1037/12326-001
- Munson, C. E., & Munson, C. E. (2002). *Handbook of clinical social work supervision* (3rd ed.). New York: Haworth Social Work Practice Press.
- Rizvi, S. L. (2010). Development and preliminary validation of a new measure to assess shame: The shame inventory. *Journal of Psychopathology and Behavioral Assessment*, 32(3), 438-447. doi:10.1007/s10862-009-9172-y
- Rüsch, N., Corrigan, P. W., Bohus, M., Jacob, G. A., Brueck, R., & Lieb, K. (2007). Measuring shame and guilt by self-report questionnaires: A validation study. *Psychiatry Research*, 150(3), 313-325. doi:10.1016/j.psychres.2006.04.018
- Samec, J. R. (1995). Shame, guilt, and trauma: Failing the psychotherapy candidate's clinical work. *The Clinical Supervisor*, 13(2), 1-17. Retrieved from <http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/ezproxy.stthomas.edu/login.aspx?direct=true&db=swh&AN=62462&site=ehost-live>

- Sheikh, S., & Janoff-Bulman, R. (2010). The “Shoulds” and “Should nots” of moral emotions: A self-regulatory perspective on shame and guilt. *Personality and Social Psychology Bulletin*, 36(2), 213-224. doi:10.1177/0146167209356788
- Shulman, L. (2010). *Interactional supervision* (3rd ed.). Washington, DC: NASW Press.
- Southern, S. (2007). Countertransference and intersubjectivity: Golden opportunities in clinical supervision. *Sexual Addiction & Compulsivity*, 14(4), 279-302.  
doi:10.1080/10720160701480808
- Tangney, J. P. (1996). Conceptual and methodological issues in the assessment of shame and guilt. *Behaviour Research and Therapy*, 34(9), 741-754. doi:10.1016/0005-7967(96)000344
- Tangney, J. P., & Dearing, R. L. (2002). *Shame and guilt*. New York: Guilford Press.
- Tracy, J. L., & Robins, R. W. (2006). Appraisal antecedents of shame and guilt: Support for a theoretical model. *Personality and Social Psychology Bulletin*, 32(10), 1339-1351.  
doi:10.1177/0146167206290212
- Tracy, J. L., Robins, R. W., & Tangney, J. P. (2007). *The self-conscious emotions: Theory and research*. New York: Guilford Press. Retrieved  
from <http://www.loc.gov/catdir/enhancements/fy0714/2007015304-t.html>; <http://www.loc.gov/catdir/enhancements/fy0730/2007015304-b.html>
- Van Vliet, K. J. (2008). Shame and resilience in adulthood: A grounded theory study. *Journal of Counseling Psychology*, 55(2), 233-245. doi:10.1037/0022-0167.55.2.233

Yourman, D. B. (2003). Trainee disclosure in psychotherapy supervision: The impact of shame. *Journal of Clinical Psychology, 59*(5), 601-609. doi:10.1002/jclp.10162

Appendix A: Recruitment Email Flyer

**University of St. Thomas/ St. Catherine University  
School of Social Work**

**Voluntary Study on exploring shame within the  
supervisory relationship**

**LOOKING FOR LICSW's  
Supervisors**

**Criterion:**

**LICSW**

**currently provide individual clinical supervision**

**currently engage in clinical social work practice with clients**

**experience supervising a minimum of 10 supervisees throughout career**

**acknowledge an awareness of shame**

**interested in discussing how to approach dealing with shame within supervisees**

**Purpose of Study:** better understand how social work supervisors  
perceive to be effective at addressing shame within their supervisees

**Commitment: at most 1 hour of your time**

**Please email or call Kendra Holloway at: [jone0330@stthomas.edu](mailto:jone0330@stthomas.edu) or 920.980.2725 if  
interested in participating in an interview or if you have further questions about the study.**

If you have any questions about your rights as a subject/participant in this research, or if  
you feel you have been placed at risk, you can contact the Chair of the Human Subjects  
Institutional Review Board, through St. Catherine University at (651) 690-7739.

## Appendix B: Recruitment Phone Script

Hello. My name is Kendra Holloway, and I am a MSW graduate student at the University of St. Thomas/St. Catherine University completing my clinical research project on exploring shame within the supervisory relationship. **Do you have a few minutes to hear about my research and decide if you would like to participate?**

The *purpose of this study* is to gain knowledge of how shame manifests within social work supervisees, and to understand how social work supervisors perceive to be effective at addressing shame within their supervisees through the supervisory relationship.

If you decide to participate, you will be asked to complete an interview (no longer than 1 hour of your time) consisting of 12 open-ended questions. The questions will prompt you to share your perceptions and experiences regarding shame within the context of the supervisory relationship. The results of this study will provide new information to inform social work supervision practice of the perceived best approaches of dealing with supervisee shame.

In order to participate in the study you must meet the following criterion:

- LICSW
- currently provide individual clinical supervision
- currently engage in clinical social work practice with clients
- experience supervising a minimum of 10 supervisees throughout career
- acknowledge an awareness of shame
- interested in discussing how to approach dealing with shame within supervisees

920-980-2725

jone0330@stthomas.edu

I received your contact information from the Minnesota Society for Clinical Social Work website. The study is being conducted by myself, Kendra Holloway, under the supervision of Dr. Lisa Kiesel Ph.D., a faculty member in the Department of Social Work.



## Appendix C: Consent Form

**Exploring Shame Within the Supervisory Relationship  
INFORMATION AND CONSENT FORM  
IRB Protocol ID: 550**

**Introduction:**

You are invited to participate in a research study investigating what social work supervisors perceive to be effective ways of approaching shame within their supervisees. This study is being conducted by Kendra Holloway, a graduate student at St. Catherine University under the supervision of Dr. Lisa Kiesel Ph.D., a faculty member in the Department of Social Work. You were selected as a possible participant in this research because you were identified from either the NASW website or by my committee member, Jane Hurley-Johncox, as a social worker whom currently provides clinical supervision to social work supervisees. Please read this form and ask questions before you agree to be in the study.

**Background Information:**

The purpose of this study is to gain knowledge of how shame manifests within social work supervisees, and to understand how social work supervisors perceive to be effective at addressing shame within their supervisees through the supervisory relationship. Approximately 8-10 people are expected to participate in this research.

**Procedures:**

If you decide to participate, you will be asked to complete an interview consisting of 12 open-ended questions. The questions will prompt you to share your perceptions and experiences regarding shame within the context of the supervisory relationship. One hour is the amount of time this researcher estimates it will take to conduct the interview, which will include time to review and sign the consent form and respond to the interview questions. Upon completion of the interview, I will debrief with you by exploring their experience of the interview. This study will take approximately 1 hour over 1 session.

**Risks and Benefits of being in the study:**

The study has minimal risks. This interview involves probing for personal or sensitive information regarding your experiences and perceptions. First, it may be uncomfortable to disclose information pertaining to your work as a clinical supervisor. Additionally, it may be distressing to share details regarding the interactions with your supervisees. These discomforts can be reasonably expected given then sensitive nature of discussing shame.

There are no direct benefits to you for participating in this research. However, this research will add to the growing body of literature on shame within the supervisory relationship. The results of this study will provide new information to inform social work supervision practice of the perceived best approaches of dealing with supervisee shame.

**Confidentiality:**

Any information obtained in connection with this research study that can be identified with you will be disclosed only with your permission; your results will be kept confidential. In any written

reports or publications, no one will be identified or identifiable and only group data will be presented. All identifying information will be de-identified during data collection.

I will keep the research results in a locked file cabinet in my residence, and only I, Kendra Holloway, and my advisor will have access to the records while I work on this project. Interviews will be audio recorded to document the interview and will allow only this researcher to review the recording for purpose of the study. The audio recordings will be stored in a password-protected file in the researcher's computer, ensuring no one else will have access to the audio recordings. All emails sent between this researcher and participants will be stored on the researcher's password-protected computer.

I will finish analyzing the data by May 31, 2016. I will then destroy all original reports and identifying information that can be linked back to you.

I will utilize a transcription service provider for the purpose of transcribing the interview audio recordings to written transcriptions. The transcriber will review and sign a transcriber confidentiality agreement consent form in order to maintain confidentiality of the participants.

**Voluntary nature of the study:**

Participation in this research study is voluntary. Your decision whether or not to participate will not affect your future relations with St. Catherine University in any way. If you decide to participate, you are free to stop at any time without affecting these relationships.

**Contacts and questions:**

If you have any questions, please feel free to contact me, Kendra Holloway, at (920) 980-2725. You may ask questions now, or if you have any additional questions later, the faculty advisor, Lisa Kiesel, at (651) 690-6709 will be happy to answer them. If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher(s), you may also contact Dr. John Schmitt, Chair of the St. Catherine University Institutional Review Board, at (651) 690-7739 or [jsschmitt@stkate.edu](mailto:jsschmitt@stkate.edu).

**Statement of Consent:**

You are making a decision whether or not to participate. Your signature indicates that you have read this information and your questions have been answered. Even after signing this form, please know that you may withdraw from the study.

I consent to participate in the study, and I agree to be audiotaped. You may keep a copy of this form for your records.

---

Signature of Participant

---

Date

---

Signature of Researcher

---

Date

## Appendix D: Interview Questions

1. Demographic Questions:  
Please describe your area of practice?  
Probes: type of setting, area of social work practice?  
What training have you received to provide clinical supervision?  
How many years have you been in practice?  
How many years of experience do you have providing clinical supervision?  
How many supervisees have you supervised throughout your career?
2. What do you see as the purpose of clinical supervision?
3. How do you describe your supervisory style? (Probes: model of supervision, theoretical framework, values that guide your supervisory practice)
4. How do you tend to approach supervisees' emotions during supervision?
5. How do you define shame?
6. How do you detect shame within your supervisees? (Probe: What does shame look like or sound like in your supervisees?)
7. What approaches do you find helpful in responding to a supervisee's shame? (Probes: Example from your supervisory experiences? What do you do, say, or not do/say?)
8. What approaches do you find harmful in responding to a supervisee's shame? (Probes: Example from your supervisory experiences? What do you do, say, or not do/say?)
9. How does the management of your own shame influence your ability to respond to supervisees' shame?
10. How does the agency or place of employment influence your ability to respond to supervisees' shame? (Probe: Are there policies or organizational culture that influence your responses?)
11. How do you evaluate the effectiveness of your approaches to dealing with supervisee shame? (Probe: Do you ask for verbal or written feedback? Use a survey?)
12. Do you have any other comments regarding this topic that I have not asked about, that you would like to share?